

Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  <b>TN5302</b>	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED  <b>08/17/2011</b>
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NAME OF PROVIDER OR SUPPLIER  <b>BAPTIST HEALTH CARE CENTER</b>	STREET ADDRESS, CITY, STATE, ZIP CODE <b>700 WILLIAMS FERRY RD LENOIR CITY, TN 37771</b>
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(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	<p>Initial Comments</p> <p>An annual Licensure survey was completed on August 15 - 17, 2011, at Baptist Health Care Center. No deficiencies were cited under Chapter 1200-8-6, Standards for Nursing Homes.</p>	N 000		

Division of Health Care Facilities

*Antonia Albert*  
LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE  
*Administrator*

(X6) DATE  
*8/26/11*